INFORMED CONSENT

My name is Chandra L. Taylor and I will be serving as your counselor. I know that starting counseling is a major decision. This form provides information about my background, state and federal laws, policies and your rights regarding counseling. Should you have questions or concerns regarding any part of the therapeutic process, feel free to discuss them with me. My education includes a Masters Degree in Counseling from Northeastern Illinois University. I am licensed by the State of Illinois as a Clinical Professional Counselor and certified by the National Board of Certified Counselors. I have served as an educator and counselor for many years. In our therapeutic sessions, I will utilize Person Centered Therapy and Rational Emotive Behavior Therapy, however alternative methods are executed when necessary to meet the needs of clients. Treatment practices, philosophy, a provisional treatment plan, limitations, risks and other terms will be discussed during the initial session. Recommendations in terms of a provisional diagnosis, frequency of appointments and supplemental services will also be offered. Based on mutual consent, a therapeutic relationship will be established.

CONFIDENTIALITY AND EMERGENCY SITUATIONS

What we discuss in therapy and the content included in my records are not shared with anyone without your written permission except: 1) diagnosis and dates of service shared with your insurance company to process claims, 2) information you tell me about physical, sexual or elder abuse (according to Illinois State Law, I am mandated to report this to the Department of Children and Family Services, 3) when you sign a release of information to have specific information shared, 4) if you tell me you are in danger of harming yourself or others, 5) information shared with my supervisor or consultant and 6) when required by law.

If you need to contact me between counseling sessions please call me at (312) 520-1335. E-mail, text messages and social networking sites are not confidential and I may not be able to respond. If an emergency situation occurs and you are not able to reach me, call 911 immediately.

Signature_____Date:_____

COORDINATION OF TREAMENT: It is important that all health care providers work together. As a result, I would like your permission to communicate with your physician, psychiatrist or any other professionals that you visit. Your permission is good for one year. If you choose not to provide your permission for me communication with those individuals, no information will be shared. Please check the correct box below.

____You may communicate with my physician, psychiatrist or other professionals
____You may not communicate with my physician, psychiatrist or other professionals.

NAME: _____
FACILITY: _____
ADDRESS: _____
PHONE: _____

NAME: _____
FACILITY: _____
ADDRESS: _____
PHONE: _____

You have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that Taylor Counseling Care has acted in reliance on such authorization.

Signature_____Date_____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

May I contact you at home (circle one) **yes no**?
May I contact you at work (circle one) **yes no?**
May I contact you by cell phone (circle one) **yes no?**
Where would you prefer to be contacted?_____
Contact number _____

***I have read and received a copy of the Notice of Privacy Practices and Client Rights document.**

Signature_____Date_____

A copy of this form will be placed in your file.